Patients given warning over surgical tools

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Nearly 60 dental and surgical patients treated March 1 at VA San Diego Healthcare System in La Jolla should receive FedEx notices today saying that tools possibly used in their care were not fully sterilized.

The vets are asked to return to the medical center for testing for viral and bacterial infections. They might also be vaccinated against hepatitis.

Dr. David Looney, a VA infectious disease specialist, said he doubts that any patient was infected because of improperly sterilized equipment. He said the risk is "so minimal, the only number that is close to the risk we're familiar with is zero."

Sterilization of medical tools involves two processes, Looney said.

First, the instruments are washed in 180-degree water for 40 minutes with a detergent that deactivates blood or tissue. That process was followed correctly, Looney said.

Second, the tools are wrapped in cloth or paper packages and placed into a sterilizer for four minutes at 273 degrees. During this vacuum process, air is extracted from the chamber before sterilizing steam is introduced.

But for several packages of surgical and dental tools sterilized late the night of Feb. 28 or early the morning of March 1, an incorrect process called gravity displacement was used. Instead of the vacuum procedure, steam was sent into the chamber to push out the air.

When gravity displacement is used, it takes longer for temperatures to rise to the level needed to kill germs. That's especially true if packages are bulky, Looney explained.

As a safety check, the medical center attaches a bacterial indicator on the outside of each package. The indicator should show that all bacteria have been killed.

It did so for the first 24 hours after the Feb. 28 or March 1 sterilization. But after 48 hours, the indicator turned positive, signaling that some of the bacteria were still living, Looney said.

So far, the center has confirmed that the suspect tools were used on two surgical patients. They might also have been used on one of seven other surgical patients and any of 49 dental patients treated March 1.

The notice, signed by VA hospital director Gary Rossio, emphasized that "the chance of contracting an infection as a result of this error is extremely low." Nevertheless, Rossio advised patients to undergo blood tests as confirmation.

"If by any chance you were infected as a result of this occurrence, the VA will provide all necessary and appropriate care required," he wrote.

Rossio closed by saying, "Please be assured we have taken steps to prevent this situation from happening again."

Looney said VA officials have consulted experts from the federal Centers for Disease Control and Prevention in Atlanta. A CDC spokeswoman said although the agency was not aware of that consultation, "in the few instances where breakdown in sterilization processes have been identified (nationally), no infections have resulted."

The mistake also was reported to the U.S. National Office of Patient Safety and the central office of VA Healthcare in Washington, D.C., Looney said. Both groups did not return phone calls seeking comment.

Looney said he will chair a VA "root cause analysis" committee, set up to conduct an internal review of the incident. One question, he said, is why it took more than two weeks from the time the error was spotted to notify VA officials and patients.

"Among the different systems issues is the notification process that didn't lead to a speedy dissemination of information," Looney said. "It took some time to identify the patients, draft a letter and get it approved."

In the meantime, he said, the medical center's staff has been retrained and the gravity displacement option deactivated.

There are no plans for an independent agency to inspect the center or review the incident, Looney said. Because the VA hospital is federally designated, the California Department of Health Services division of licensing and certification has no jurisdiction.

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